EXHIBIT 3

CIBC World Markets
16th Annual Healthcare Conference
November 7-9, 2005, The Waldorf-Astoria, New York City, NY

CONOR MEDSYSTEMS, INC.

Webcast presentation
November 8, 2005

[START TAPE 1 SIDE A]

JOHN: Okay. Hello, everybody. Our next presenting company is Conor Medsystems and sector out performer rated stock. You've heard a lot from us about Conor, very innovative vascular drug delivery company. That's the way we like to describe it as I think the company would agree with.

And with us today is Chairman and CEO Frank Litvack who'll go through the presentation and then we'll see you guys in the breakout room, which is the center room, the Louis XVI, center.

So with that, Frank.

MR. FRANK LITVACK: Thank you, John, and thanks, everybody, for coming and thanks for inviting us here today at the meeting. It looks like it's a big success.

If you don't mind just take a moment to carefully read this forward-looking statement disclaimer.

So I'm going to focus a little bit on the high level of what's going on with our company, the technology in the pipeline, talk a little bit about our business and the milestones that are coming up.

So just to reiterate what John said, we view ourselves as an innovative controlled vascular drug delivery technology. And our principal product is a novel and proprietary stent, which principally uses reservoirs versus a surface coating, and this allows for enhanced control of drug release with respect to kinetic, multiple drugs and directional control.

And very importantly, we early on made a decision to focus entirely on bio-erode-able polymers with the idea being that no potentially toxic or residual polymer should be left after the drug is delivered.

The polymers are there just to deliver the drug. It's not there for any other reason and we attempt to match the drug delivery to the tissues physiology.

Before going into any of our own technologies, I think it's worthwhile taking a moment to take a 40,000 foot look at the remaining challenges of the first generation of existing coated drug-eluting stents.

And there's a few areas that we think provide room for improvement and they actually provide opportunity for us and other players.

First of all, the recurrence rate in the real world is still sub-optimal and we think there's an opportunity there to optimize existing drugs and to potentially look at some newer agents and/or combinations of drugs.

Second, the issue of stent thrombosis needs to kind of be bifurcated into early and sub-acute stent thrombosis, which may be just a bit more frequent with all drug-eluting stents than it is with bare stents.

We certainly have had our .3 to .6% incidence of early stent thrombosis. There may be an opportunity there, to put in an anti-platelet or anti-thrombotic agent on the stent.

Perhaps more importantly because it's so difficult to predict and so insidious is this new concept of delayed stent thrombosis, a previously unknown condition that seems to occur months or even years after the procedure.

We think we have a real opportunity there because we're using a fully erode-able polymer and complete drug discharge. Bare stents do not have late stent thrombosis.

This is unique to the current generation of drug-eluting stents and we think that we may

have a solution for that. Then of course, coated stents provide limits on dual drugs, kinetics, directional, et cetera, et cetera.

Looking at our product opportunities, this includes our current products and some of our futuristic pipeline, we like to divide the world up into restenosis, restenosis plus potential inhibition of thrombosis, and then beyond restenosis.

Our first product, the product upon which the commercial or near-term commercial possibilities for the company is based is the CoStar Paclitaxel eluting stent. We are anticipating a CE mark for European approval for later this year or in the first portion of next year.

We will be distributing that product in Europe through our European marketing partner, Biotronics.

In addition, our U.S. pivotal trial is well under way. We are enrolling a 1700 patient randomized non-impurity trial versus taxis, including both single and multi-vessel disease. And we expect enrollment in that trial to be complete at around the end of the first quarter

of next year.

We're very actively looking at next generation restenosis products. We licensed to Necrolemis [phonetic] from Novartis. I'm going to talk about that in a little while.

We've got we believe the first dual drug stent with independent release - sustained release kinetics combining Necrolemis plus Paclitaxel to attack both the inflamed inflammation and proliferative pathways.

And we're planning to start the OUS pivotal trials with our next generation of drugs on our platform sometime next year.

With respect to the thrombosis story, this is still in the experimental phase. We're looking at a number of anti-platelet and anti-thrombotic agents. This may or may not result in a product that gets into humans, but it's an intriguing concept.

Further, we're also looking at dealing with stents that can deliver drugs to potentially reduce myocardial infarct size and through luminol elution, we're looking right now at insulin. We have a couple other drugs on the docket as well.

So what we believe is that we have a platform that can compete effectively in today's market, but also has legs and wherewithal to develop a product that can move us and differentiate us beyond the current players.

This is a picture of the cobalt chromium Conor stent. The major difference is that it is a stent that's full of reservoirs. These reservoirs become the depots for the drugs.

The CoStar is made out of cobalt chromium. We believe it is the lowest profile or skinniest stent of all the stents that are currently either on the market or in clinical trial.

The reservoirs provide an important degree of control over drug release. How you load the drug in the reservoir, the drug polymer combination, can dictate the kinetic release curve as well as the direction.

Again, remember we're using erode-able polymers. We can have bi-directional release, uni-directional release, single drugs from the same reservoir or drugs coming from adjacent reservoirs with independent release kinetics.

So there's a lot of permutations and combinations, a lot of degrees of freedom that

we can use.

In fact, we used as a kinetic control to do the trial that I think put us on the map at least in the medical and scientific community, and that's the PISCES trial.

And the PISCES trial, which to the best of my knowledge is a unique trial, we actually used six different formulations of two doses. So we had a 10 microgram dose, a 30 microgram dose -- I remind you the dose on etaxis [phonetic] is about 110 for a 16 millimeter stent microgram of Paclitaxel.

And we had three different release rates: a very fast release rate, an intermediate, and a longer release rate. And we wanted to see if kinetics and/or dose affects efficacy because we were choosing the formulation basket for our clinical trials.

What we showed in this PISCES trial was that long release was the most important determinant. So both the 10 micrograms, 30-day in vitro release and the 30 micrograms, 30-day in vitro release actually resulted in the best results.

Whereas the same dose or even a higher dose with a short release resulted in results that

were barely better than a bare metal stent.

This data helped kind of teach the world that you can actually modulate the efficacy of a drug by releasing it in a manner that is consistent with its physiologic requirement.

We then went on and did a number of OUS trials. I won't go through them in detail. We talked about the PISCES, but the next important trial that we did was the EuroSTAR trial, which was our European pivotal trial.

I'm going to present you with the dose that is going to be our commercial dose, which turns out to be our 10 micrograms by 30-day in vitro release. And of course, our CoStar II trial, which is the U.S. pivotal, which is still enrolling.

The EuroSTAR trial, which we had previously presented basically showed very, very competitive six-month results. The binary stenosis result in stent was 3.4% and in segment was 4.7%. The late loss in stent was 0.26 millimeters and in segment was 0.07 millimeters.

We believe this is the lowest late loss results that have ever been shown with a taxile [phonetic] stent.

When we put together this kind of McKinsey like clinical utility chart where we put in-stent late loss, lower being better up to a certain point - you don't want to be too, too low - and a crossing profile lower to the right being better and you compare the competitive products, we thought that we ended up in that coveted right lower quadrant with a very low crossing profile and a low in-stent late loss.

So we think that what I've shown you here is that we've got a very, very - the first two legs of the stool, the first being deliverability. We think the cobalt chromium stent is as deliverable as any stent out there. And efficacy, we've shown you excellent efficacy data.

We basically have now completed our OUS trials with our pivotal and our dose ranging. And this is an interesting slide that we've never shown before.

Basically, it's a three-dimensional slide which combines data from all our OUS trials and it looks at late loss on the Y axis for three different doses. We also used a low dose, 3 micrograms, 10, which is our pivotal dose, and

30 micrograms and for faster release and for longer release, 10 days and 30 days.

And as you can see, you kind of threaded the needle with Taxil [phonetic], which is a kind of a difficult drug to use and the 10 micrograms, 30-day release which we're using in the European commercial product and in our U.S. pivotal, ultimately U.S. commercial product, was really developed or determined by virtue of all these dosing kinetic range studies.

And I think nobody has done this before in drug-eluting stent and this is part of the power of the kinetic control of reservoir based drug technology.

So we've talked about deliverability. We've talked about efficacy. What about safety?

We think that we may well have a long-term story to tell there. This is an example of a Connor stent explanted from a pig at seven days and you can see that the polymer is intact. If you look at the middle of the reservoir, it looks like it's beginning to start to erode a little bit.

However, if you come back at a 180 days, you can see that there is no polymer left on the

stent. Similarly, if we do chemical assays of the pig artery and the explanted skin, we have no drug and no polymer left at approximately six months in either the stent or the artery in the porcine model.

We believe that this is a very, very important potential advantage because we don't have drug and polymers sitting in the patient's arteries for the rest of the patient's life.

In fact, when we look at our OUS studies and we look at the patients that have gone well beyond six months now that have - are off Plavix six months per protocol, we have 845 stents and we have fortunately not had a single case of delayed or stent thrombosis reported to us.

Now, this data obviously requires more follow up both temporally and numerically, but we believe that it presents a very interesting hypothesis to the medical community and it's a hypothesis that we believe may well turn out to be fully validated in the years to come.

Talking a little bit about our pipeline, we're very excited to moving on to yet our next generation of drugs. We have a philosophy that we want to obsolete our own products.

We've been very, very innovative and we had the ability to expediently develop product. Kinecrolemis [phonetic] is a potent inhibitor of inflammatory cytokines. As you know, inflammation is an important player in vascular disease.

It does not, however, inhibit Emptor, as does Rapamycin and Everolimus. And therefore, does not inhibit endothelial cell proliferation, which is considered important.

Endothelial cells are considered important because they coat the surface of the stent. Inflammation, as I mentioned before, is an important factor in both vulnerable plaque and restenosis.

And a drug that inhibits inflammation can have some broad applications. We've now presented our earlier - at TCT, we presented our pre-clinical data on our new product, which we hope to move into the clinic.

This slide shows you a bare cobalt chromium stent on the left and Kinecrolemis with both a fast release and a slow release on the right. We've demonstrated about a 40% reduction in the original hyperplasia in the 30-day porcine

model.

I will also say that this fast release in our system is actually still about two plus months. The slow release is about six months in vivo. Remember we showed you the Taxil also about six months.

We believe that by moving to a faster release, that's two months, we are driving drug early into the artery when inflammation is very, very important. We're also getting rid of the drug and polymer even earlier, which hopefully will allows us to revert to a bare stent even earlier.

When we look at the data on neointimal thickness, we see about a 40% reduction in the neointimal thickness on the histology. That's an important metric of efficacy in the porcine model.

We also interestingly noted that even as compared to a bare stent, we're not talking about it compared with a Taxil stent, but even as compared with a bare stent, we had a statistically significant reduction in endothelial - in inflammation both in the adventitia [phonetic] and the entoma in the

Kinecrolemis stent.

So it's quite possible that the efficacy is in fact being driven by this anti-inflammatory property and the inhibition inflammation should theoretically promote rapid re-endotheliazation and healing and hopefully provide a kinder, simpler - a kinder and gentler solution.

We, however, also believe that there are certain recalcitrant patients like diabetics and patients with small vessels that have higher rates of restenosis and in that cohort we're looking at a dual drug stent.

This is a - we believe the first of its kind dual drug stent with both Kinecrolemis and Paclitaxel independent release kinetics coming from alternating reservoirs. So it's the faster or two month release with Paclitaxel and the six month in vivo release of Kinecrolemis and the six month release of Paclitaxel.

We are well into our pre-clinical work. This is an example of outstanding efficacy from the dual drug combination. This occurred without the expense of increased inflammation. So we - the Kinecrolemis actually again inhibited inflammation.

And we're very excited about bringing this product potentially into the clinic and what we showed here with the dual drug Paclitaxel Kinecrolemis stent is that - was the lowest intimal thickness we've seen in any of our animal studies so far.

So looking into 2005 - back into 2005 and forward into 2006, let's just review what we've done in 2005 and what the important business and commercial milestones are in the next several months.

We did sign the Novartis agreement for three compounds. We pretty much settled in on the Kinecrolemis. The other two compounds we probably will not bring forward.

We presented the positive European pivotal data. We got a CE mark on our bare cobalt-chromium stent. We're not commercializing that product because it's a commodity, but it's an important component of the CE mark on the drug stent.

We achieved ISO certification on our Irish manufacturing facility so we're geared up there for commercialization.

We commercially launched the cobalt-chromium

drug eluting CoStar stent in a few non-regulated countries -- India, Venezuela, Malaysia, and a few other such countries.

And last quarter we generated a million dollars in revenue from these very limited market opportunities.

We're well under way with our CoStar II pivotal U.S. trial and I've shown a few moments ago our pre-clinical data with the Novartis compounds and the dual drug is looking very interesting.

What are we planning to do over the next several months? As mentioned, we're hopeful that a CE mark is forthcoming either later this year or early next year, and that will be commercialized in the European community in partnership with Biotronic.

Biotronic has about 70 to 80 direct sales reps and some sub-dealers in some countries. Biotronic is the largest independent European medical device company. They have both rigid rhythm management division and an interventional division.

In the interventional division, they have bare stents, wires, balloons, guide catheters,

peripheral stents and they're also a leader in the bio-erode-able stent area with the magnesium bio-erode-able stent that you may have heard about.

We hope to complete the enrollment of CoStar II pivotal trial around the end of the first quarter, around April 1st, which should allow us to file the last module to the PMA around the beginning of 2007 and approval toward the end of 2007.

And we fully expect, barring some unforeseen incidents with the currently cooking pre-clinical data to begin an OUS clinical trial with the Novartis compound.

Our strategy right now is to have a three-arm trial with a control, Kinecrolemis and the combination of Kinecrolemis plus Paclitaxel to kick off the next generation of our products and hopefully demonstrate not only efficacy, have two shots on goal with two new products, but also demonstrate the possibilities for dual drug-eluting stents which could lead to yet further opportunities both in business development and in product development.

Thank you very much. I think that's all I

have to say and we have a breakout in the Louis XVI. Louis - okay, Louis XVI upstairs.

Okay. Thank you very much.

[END TRANSCRIPT]

C E R T I F I C A T E

The prior proceedings were transcribed from audio files and have been transcribed to the best of my ability.

Signature: Marianne Fike

Date: November 15, 2005